

Clark University Health Services Graduate Immunization Record

Name: _____ Date of Birth: _____ Gender: Male Female Trans
 (Last) (First)
 Cell Phone: _____ Email: _____ Department: _____ University Housing: Yes No
 Clark ID #: _____ Year Entered: _____

Required Vaccines					
Vaccine	Date 1	Date 2	Date 3	Date 4	Date 5
MMR (2) OR					
Measles Titer *		<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune			
Mumps Titer *		<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune			
Rubella Titer *		<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune			
Hepatitis B (3) OR				<input type="checkbox"/> 2 dose series (adolescent)	
Hepatitis B Titer* (HBsAB)		<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune			
Meningitis within the past 5 years		<input type="checkbox"/> Signed Waiver			
Tdap within the past 10 years					
Varicella (2) OR					
Varicella Titer * OR		<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune			
History of Varicella Disease					
TB test - PPD or IGRA if high risk within the past 6 months		PPD _____ mm IGRA <input type="checkbox"/> + <input type="checkbox"/> -	IF + Chest X-ray date _____	Chest X-ray result _____	Prophylactic Med completed _____

*Attach laboratory report of all titers.

Recommended Vaccines					
Vaccine	Date 1	Date 2	Date 3	Date 4	Date 5
HPV vaccine					
Hepatitis A					
Pneumococcal					

Healthcare provider: _____
 Please print Last First NP, PA, MD, DO

Address _____

Phone #: _____ Fax #: _____

Signature of Healthcare provider: _____ Date: _____